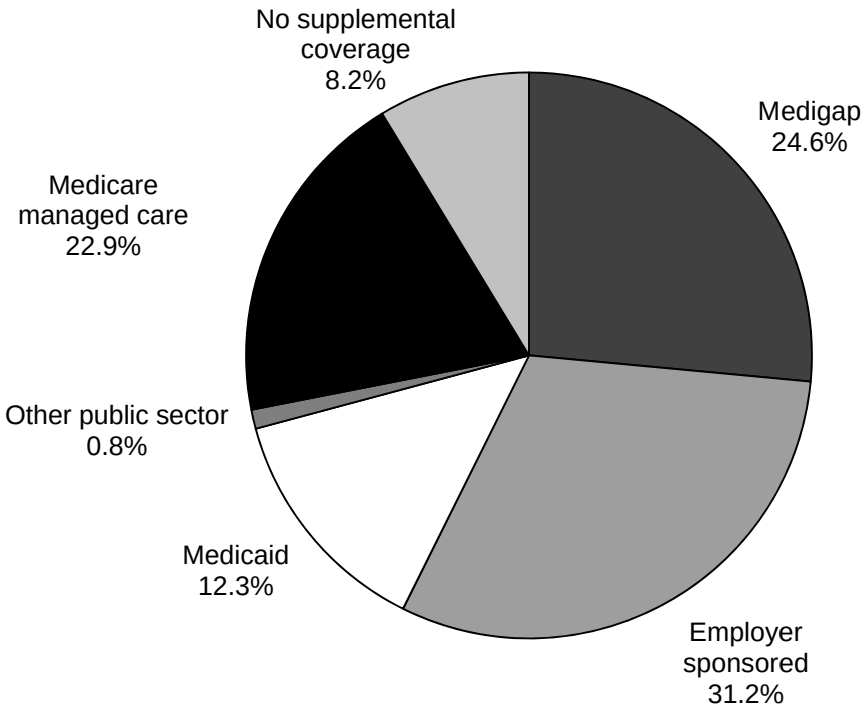
SECTION 5

Medicare beneficiary and other payer financial liability

Chart 5-1. Sources of supplemental coverage among noninstitutionalized Medicare beneficiaries, 2007



Note: Beneficiaries are assigned to the supplemental coverage category that applied for the most time in 2007. They could have had coverage in other categories throughout 2007. "Other public sector" includes federal and state programs not included in other categories. Analysis includes only beneficiaries not living in institutions such as nursing homes. It excludes beneficiaries who were not in both Part A and Part B throughout their enrollment in 2007 or who had Medicare as a second payer.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2007.

- Most beneficiaries living in the community have coverage that supplements or replaces the Medicare benefit package. About 92 percent of beneficiaries have supplemental coverage or participate in Medicare managed care.
- About 56 percent have private-sector supplemental coverage such as medigap (about 25 percent) or employer-sponsored retiree coverage (about 31 percent).
- About 13 percent have public-sector supplemental coverage, primarily Medicaid.
- Twenty-three percent participate in Medicare managed care. This care includes Medicare Advantage, cost, and health care prepayment plans. These types of arrangements generally replace Medicare coverage and often add to it.
- The proportion of beneficiaries who have managed care enrollment on this diagram (about 23 percent) is smaller than the proportion listed in Section 9 (24 percent), because this chart reflects 2007 data and Section 9 reflects 2011 data. Managed care enrollment grew substantially in the intervening years.

Chart 5-2. Sources of supplemental coverage among noninstitutionalized Medicare beneficiaries, by beneficiaries' characteristics, 2007

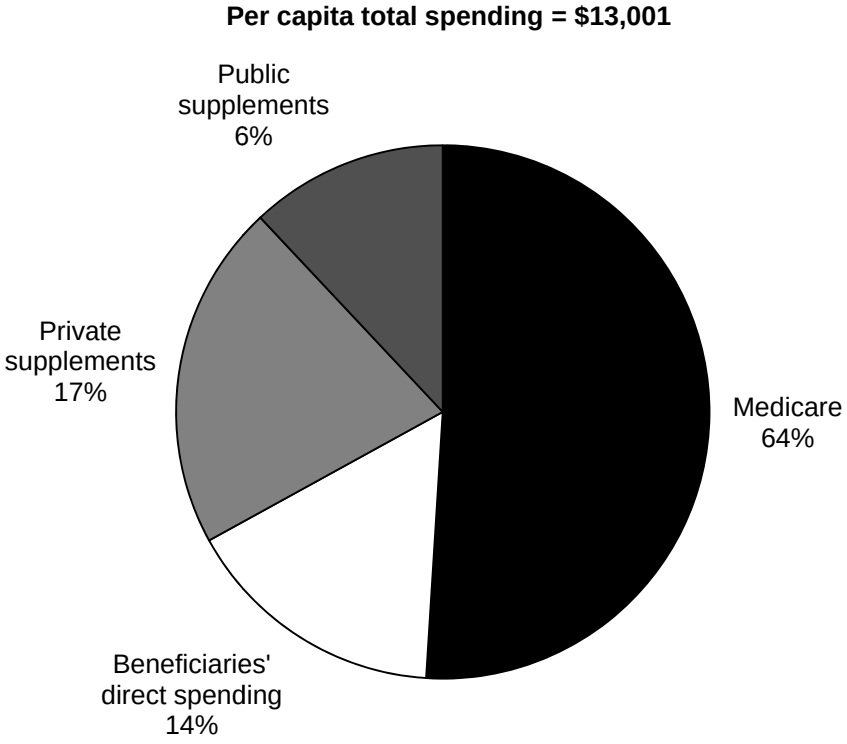
	Number of beneficiaries (thousands)	Employer-sponsored insurance	Medigap insurance	Medicaid	Medicare managed care	Other public sector	Medicare only
All beneficiaries	**38,364**	**31%**	**25%**	**12%**	**23%**	**1%**	**8%**
Age							
Under 65	5,635	19	5	39	17	1	19
65–69	8,751	35	25	7	23	1	9
70–74	7,803	32	27	9	25	1	6
75–79	6,615	33	27	8	26	1	5
80–84	5,224	34	32	7	22	1	5
85+	4,336	33	33	9	23	1	5
Income status							
Below poverty	6,117	9	13	46	21	1	10
100% to 125% of poverty	3,502	13	21	27	27	1	11
125% to 200% of poverty	7,829	24	26	10	26	2	13
200% to 400% of poverty	11,462	41	26	1	24	1	7
Over 400% of poverty	9,379	46	31	0	19	0	4
Eligibility status							
Aged	32,546	33	28	8	24	1	6
Disabled	5,476	18	5	39	17	1	19
ESRD	291	28	27	21	13	0	11
Residence							
Urban	29,286	32	23	11	27	1	7
Rural	9,052	30	31	17	9	1	12
Sex							
Male	17,080	33	22	11	23	1	11
Female	21,285	30	26	14	23	1	6
Health status							
Excellent/very good	15,852	35	28	6	24	1	6
Good/fair	19,107	30	23	15	22	1	9
Poor	3,178	24	17	26	20	1	13

Note: ESRD (end-stage renal disease). Beneficiaries are assigned to the supplemental coverage where they spent the most time in 2007. They could have had coverage in other categories throughout 2007. Medicare managed care includes Medicare Advantage, cost, and health care prepayment plans. "Other public sector" includes federal and state programs not included in other categories. In 2007, poverty was defined as $9,944 for people living alone and $12,550 for married couples. "Urban" indicates beneficiaries living in metropolitan statistical areas (MSAs). "Rural" indicates beneficiaries living outside MSAs. Analysis includes beneficiaries living in the community. Number of beneficiaries differs among boldface categories because we exclude beneficiaries with missing values.

Source: MedPAC analysis of 2007 Medicare Current Beneficiary Survey, Cost and Use file.

- Beneficiaries most likely to have employer-sponsored supplemental coverage are those who are above age 64, are higher income (above 200 percent of poverty), are eligible due to age or end-stage renal disease (ESRD), and report better than good health.
- Medigap is most common among those who are age 80 or older, are middle or high income (above 125 percent of poverty), are eligible due to age or ESRD, are rural dwelling, are female, and report excellent or very good health.
- Medicaid coverage is most common among those who are under age 65, are low income (below 125 percent of poverty), are eligible due to disability, and report poor health.
- Lack of supplemental coverage (Medicare coverage only) is most common among beneficiaries who are under age 65, have income below 200 percent of poverty, are eligible due to disability, are rural dwelling, are male, and report poor health.

Chart 5-3. Total spending on health care services for noninstitutionalized FFS Medicare beneficiaries, by source of payment, 2007



Note: FFS (fee-for-service). Private supplements include employer-sponsored plans and individually purchased coverage. Public supplements include Medicaid, Department of Veterans Affairs, and other public coverage. Direct spending is on Medicare cost sharing and noncovered services but not supplemental premiums. Analysis includes only FFS beneficiaries not living in institutions such as nursing homes. Numbers may not sum to 100 percent due to rounding.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2007.

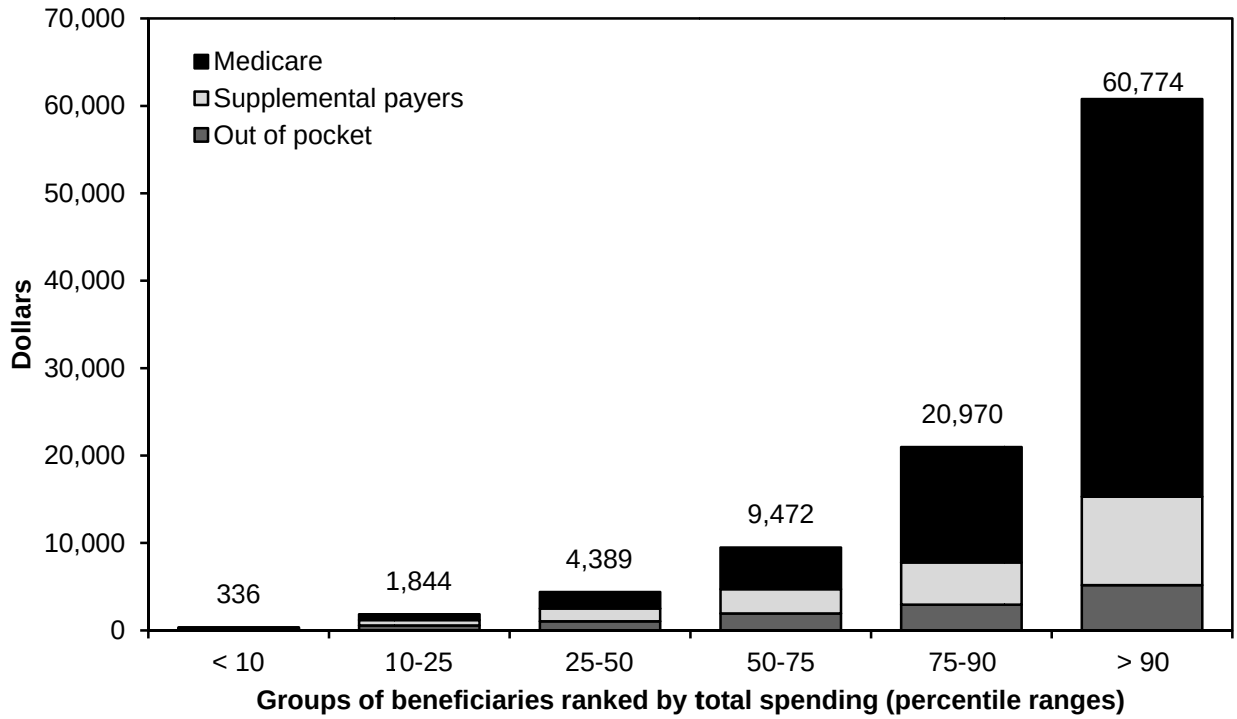
- Among fee-for-service (FFS) beneficiaries living in the community, the total cost of health care services (defined as beneficiaries' direct spending as well as expenditures by Medicare, other public-sector sources, and all private-sector sources on all health care goods and services) averages $13,001. Medicare is the largest source of payment; it pays 64 percent of the health care costs for FFS beneficiaries living in the community, an average of $8,299 per beneficiary. The level of Medicare spending in this chart differs from the level in Chart 2-1 because this chart excludes beneficiaries in Medicare Advantage and those living in institutions, while Chart 2-1 represents all Medicare beneficiaries.

- Private sources of supplemental coverage—primarily employer-sponsored retiree coverage and medigap—paid 17 percent of beneficiaries' costs, an average of $2,182 per beneficiary.

- Beneficiaries paid 14 percent of their health care costs out of pocket, an average of $1,798 per beneficiary.

- Public sources of supplemental coverage—primarily Medicaid—paid 6 percent of beneficiaries' health care costs, an average of $721 per beneficiary.

Chart 5-4. Per capita total spending on health care services among noninstitutionalized FFS beneficiaries, by source of payment, 2007



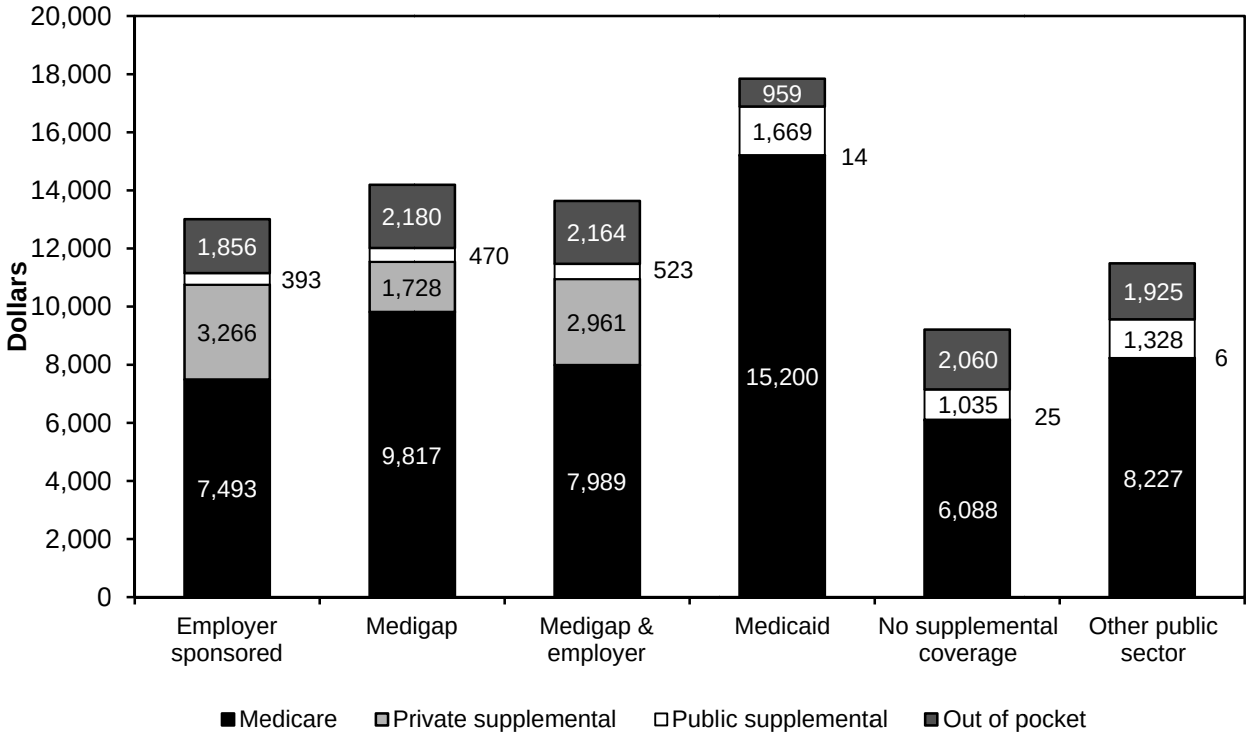
Note: FFS (fee-for-service). Analysis includes FFS beneficiaries not living in institutions such as nursing homes. Out-of-pocket spending is on Medicare cost sharing and noncovered services.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2007.

- Total spending on health care services varies dramatically among fee-for-service (FFS) beneficiaries living in the community. Per capita spending for the 10 percent of beneficiaries with the highest total spending averages $60,774. Per capita spending for the 10 percent of beneficiaries with the lowest total spending averages $336.

- Among FFS beneficiaries living in the community, Medicare pays a larger percentage as total spending increases, and beneficiaries' out-of-pocket spending is a smaller percentage as total spending increases. For example, Medicare pays 64 percent of total spending for all beneficiaries but pays 75 percent of total spending for the 10 percent of beneficiaries with the highest total spending. Beneficiaries' out-of-pocket spending covers 14 percent of total spending for all beneficiaries but only 9 percent of total spending for the 10 percent of beneficiaries with the highest total spending.

Chart 5-5. Variation in and composition of total spending among noninstitutionalized FFS beneficiaries, by type of supplemental coverage, 2007



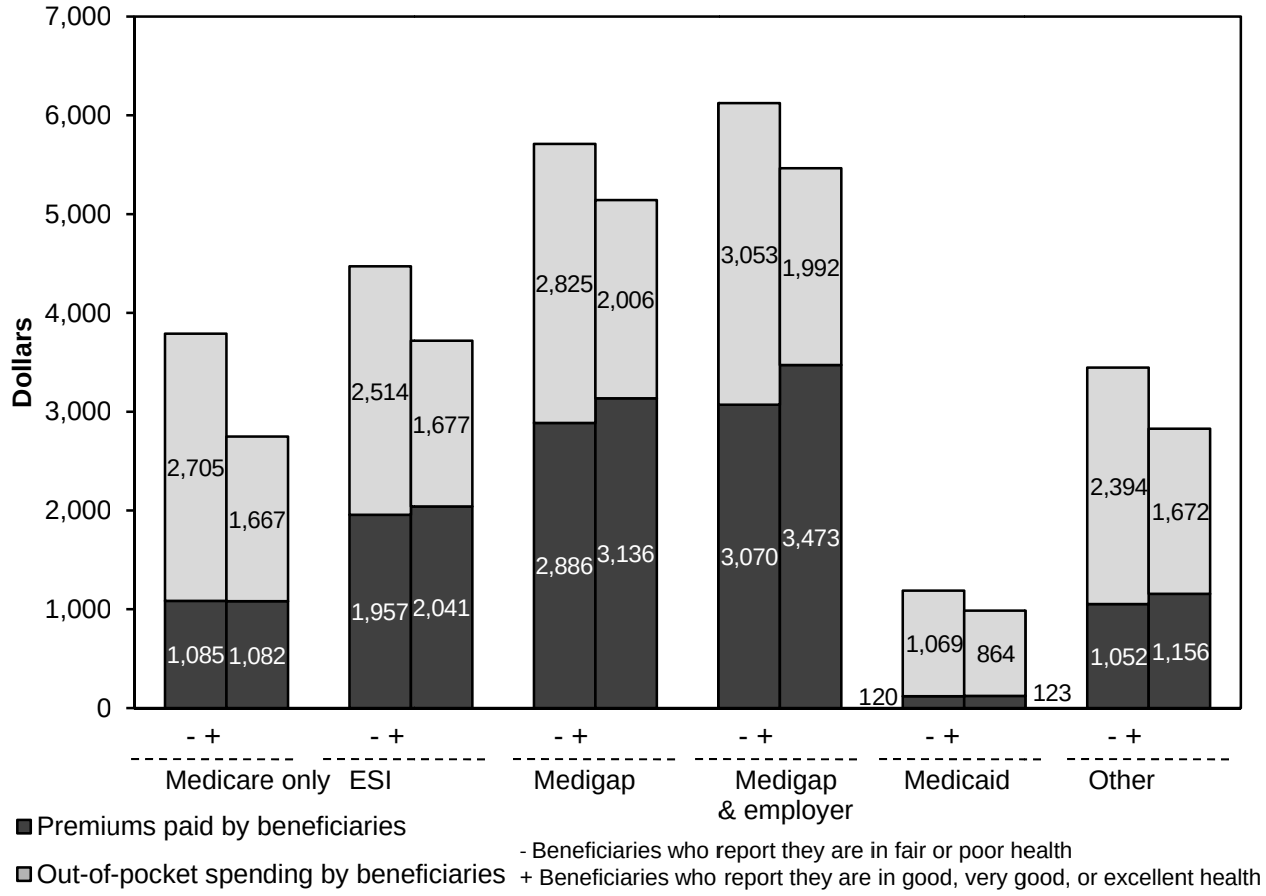
Note: FFS (fee-for-service). Beneficiaries are assigned to the supplemental coverage category that applied for the most time in 2007. They could have had coverage in other categories throughout 2007. "Other public sector" includes federal and state programs not included in the other categories. "Private supplemental" includes employer-sponsored plans and individually purchased coverage. "Public supplemental" includes Medicaid, Department of Veterans Affairs, and other public coverage. Analysis includes only FFS beneficiaries not living in institutions such as nursing homes. It excludes beneficiaries who were not in both Part A and Part B throughout their enrollment in 2007 or had Medicare as a second payer. Out-of-pocket spending is on Medicare cost sharing and noncovered services but not supplemental premiums.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2007.

- The level of total spending (defined as beneficiaries' out-of-pocket spending as well as expenditures by Medicare, other public-sector sources, and all private-sector sources on all health care goods and services) among fee-for-service beneficiaries living in the community varies by the type of supplemental coverage they have. Total spending is much lower for those beneficiaries with no supplemental coverage than for those beneficiaries who have supplemental coverage. Beneficiaries with Medicaid coverage have the highest level of total spending, 94 percent higher than those with no supplemental coverage.

- Medicare is the largest source of payment for beneficiaries in each supplemental insurance category, but the second largest source of payment differs. Among those with employer-sponsored, medigap, medigap plus employer, and Medicaid, supplemental coverage coverage—public and private combined—is the second largest source of payment. However, among those with other public and Medicare-only coverage, beneficiaries' out-of-pocket spending is the second largest source of payment.

Chart 5-6. Out-of-pocket spending for premiums and health services per beneficiary, by insurance and health status, 2007



Note: ESI (employer-sponsored supplemental insurance).

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2007.

- This diagram illustrates out-of-pocket spending on services and premiums by beneficiaries' supplemental insurance and health status. For example, beneficiaries who have only traditional Medicare coverage (Medicare only) and report fair or poor health had an average of $1,085 in out-of-pocket spending on premiums and $2,705 on services. Those who have Medicare-only coverage and report good, very good, or excellent health had an average of $1,082 in out-of-pocket spending on premiums and $1,667 on services.
- Insurance that supplements Medicare does not shield beneficiaries from all out-of-pocket costs. Beneficiaries who report being in fair or poor health spend more out of pocket for health services than those reporting good, very good, or excellent health regardless of the type of coverage they have to supplement Medicare.
- Despite having supplemental coverage, beneficiaries who have employer-sponsored insurance (ESI) or medigap have out-of-pocket spending that is comparable to or more than those who have only coverage under traditional Medicare (Medicare only). This result likely reflects the fact that beneficiaries who have ESI or medigap have higher incomes and are likely to have stronger preferences for health care.
- What beneficiaries actually pay out of pocket varies by type of supplemental coverage. For those with medigap, out-of-pocket spending generally reflects the premiums and costs of services not covered by Medicare. Beneficiaries with ESI usually pay less out of pocket for Medicare noncovered services than those with medigap but may pay more in Medicare deductibles and cost sharing.

Web links. Medicare beneficiary and other payer financial liability

- Chapter 1 of the MedPAC March 2011 Report to the Congress provides more information on Medicare program spending.

  www.medpac.gov/chapters/Mar11_ch01.pdf

- Chapter 1 of the MedPAC March 2010 Report to the Congress provides more information on Medicare program spending.

  www.medpac.gov/chapters/Mar10_ch01.pdf

- Chapter 1 of the MedPAC March 2009 Report to the Congress provides more information on Medicare program spending.

  http://www.medpac.gov/chapters/Mar09_ch01.pdf

- Chapter 3 of the MedPAC June 2011 Report to the Congress discusses beneficiaries' supplemental coverage, cost sharing, and health care use as well as program spending.

  http://medpac.gov/chapters/Jun11_ch03.pdf

- Chapter 2 of the MedPAC June 2010 Report to the Congress discusses the effect supplemental coverage has on beneficiaries' cost sharing, their health care use, and program spending.

  www.medpac.gov/chapters/Jun10_ch02.pdf

- Appendix B of the MedPAC June 2004 Report to the Congress and Chapter 1 of the MedPAC June 2002 Report to the Congress provide more information on Medicare beneficiary and other payer financial liability.

  www.medpac.gov/publications/congressional_reports/June04_AppB.pdf

  www.medpac.gov/publications/congressional_reports/Jun2_Ch1.pdf